DOCUMENT RESUME

ED 381 269 PS 023 178

AUTHOR	Shearer, Christopher A.; Holschneider, Silvia O. M.
TITLE	Starting Young: School-Based Health Centers at the Elementary Level.
INSTITUTION	Institute for Educational Leadership, Washington, D.C.; National Health Education Consortium, Washington, DC.
SPONS AGENCY	National Association of Elementary School Principals, Washington, D.C.; Prudential Foundation, Newark, N.J.
REPORT NO	ISBN-0-937846-42-2
PUB DATE	95
NOTE	40p.; Funding also provided by the Honeywell Foundation.
AVAILABLE FROM	National Health and Education Consortium, Institute for Educational Leadership, 1001 Connecticut Avenue, N.W., Suite 310, Washington, DC 20036 ($10).
PUB TYPE	Reports - Descriptive (141)
EDRS PRICE	MF01 Plus Postage. PC Not Available from EDRS.
DESCRIPTORS	*Child Health; Elementary Education; *Elementary Schools; Federal Aid; Federal Legislation; *Health Promotion; Integrated Services; Program Descriptions; *School Health Services; State Aid; State Legislation
IDENTIFIERS	National Health Education Consortium; Program Characteristics; *School Based Health Clinics; School Based Services

ABSTRACT

Noting that most school-based health care is provided at the secondary level, this report provides background and a rationale for implementing such services at the elementary school level. The first section of the report addresses several questions about school-linked health services, including: what are school-based health centers, why should they be placed in elementary schools, how are they funded, and how do they meet children's health and educational needs? This section also examines how state and federal governments have supported school-based health centers. A case study of a medical center that conducts a school-based health program, and comments on the need for a national focus on elementary school health are also included in this section. The second part of the report is a series of appendices describing model programs and legislation at the local, state, and federal levels. Appropriate contacts for further information are also listed. Included is an overview of the National Health and Education Consortium and a list of its members. (BAC)

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Starting Young:

School-Based Health Centers at the Elementary Level

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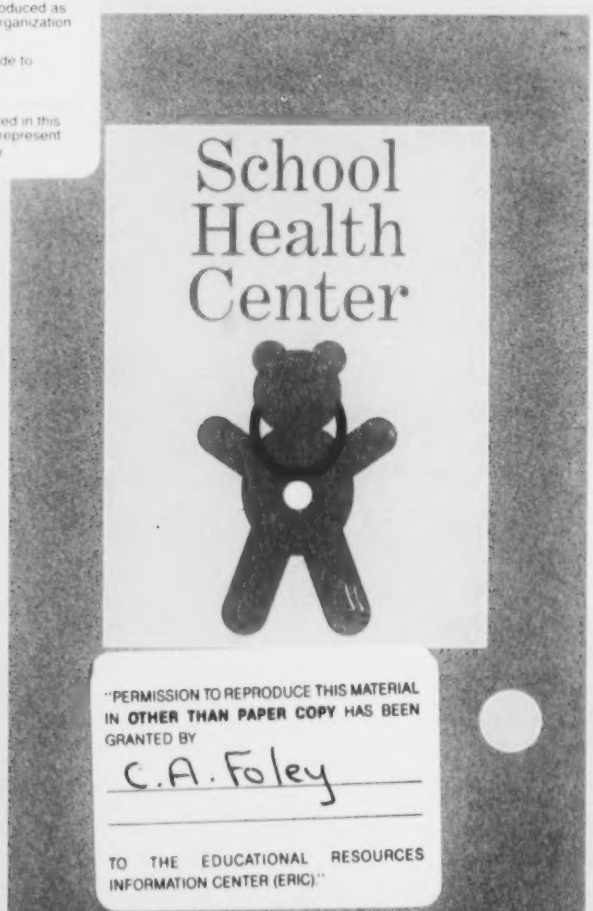

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A Special Report of the National Health & Education Consortium

This report was made possible by the generous support of The Honeywell Foundation and The National Association of Elementary School Principals

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Acknowledgments

The National Health & Education Consortium would like to thank the following people for sharing their time and expertise during the development of this report — Silvia Holschneider, formerly of NHEC, and Christopher Shearer, NHEC, who jointly authored the report; and our review panel: Margaret Dunkle, Policy Exchange at the Institute for Educational Leadership; Kate Fothergill, Columbia University School Health Policy Initiative; Bettina Yaffe Hoerlin, Elementary School-Based Health Initiative; Julia Graham Lear, Making The Grade Program; Deborah Hauser-McKinney, Advocates for Youth; and Karla Shepard, The Conservation Company. This report was designed by Patti Bangert Design.

We would like to thank the Honeywell Foundation for its generous financial support of *Starting Young: School-Based Health Centers at the Elementary Level*. We also would like to thank the National Association of Elementary School Principals for partnering with us and for providing additional funding for this report.

We greatly appreciate the Prudential Foundation's ongoing support of the National Health & Education Consortium.

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Suggested citation style: (report citation) Shearer, Christopher A. and Silvia O. M. Holschneider. *Starting Young: School-Based Health Centers at the Elementary Level*. Washington, DC: National Health & Education Consortium, 1995.

ISBN 0-937846-42-2

NAESP

National Association of
Elementary School Principals

Dear Reader:

In 1950, the United States ranked sixth-lowest in the world in infant mortality; today it ranks 21st, behind Spain and Singapore, and we are seeing new outbreaks of childhood diseases that we thought had been eradicated. In the 1980s, the U.S. Public Health Service set itself a goal of reducing measles to 500 cases a year by 1990. Instead, a lack of immunizations produced 500 cases and one preschooler death each week, and a 1991 measles epidemic in Dallas that could have been prevented by $45,000 in vaccines cost at least $1 million to treat.

Elementary school principals see other health-related cases which, while not fatal, are almost equally tragic: youngsters who have been regarded as academically slow, sometimes being held back for a year, later prove to have modest defects in hearing or sight that, once detected, are easily overcome with hearing-aids or glasses. These youngsters, in a sense, are the lucky ones. How many other children labor year after year with undetected disabilities until they finally conclude that they are "no good" at learning?

In both cases, the underlying problem is the inability of many parents to afford regular, preventive visits to a physician. Some day, one hopes, we will eliminate family income as the dividing line between children who receive professional attention and those who don't.

Meanwhile, if parents can't or won't bring their kids to the doctor, it makes educational as well as medical sense to bring health professionals to the kids, at the place where our youngest can be most easily found and screened: their elementary school. The following report, co-sponsored by the National Association of Elementary School Principals (NAESP) and the Honeywell Foundation, is a first effort to document federal, state and local initiatives aimed at placing good health only steps away from the classroom.

For our children's sake, I hope you find this report useful.

Samuel G. Sava

Samuel G. Sava
Executive Director
National Association of Elementary School Principals

Preface

The Honeywell Foundation is pleased to help make possible this valuable report on the emerging elementary school-based health movement. As we all know, school-based clinics are fast gaining ground as a viable vehicle for addressing the pressing health needs of students and for providing preventive screenings and education.

But if prevention is to become the watchword of the next decade — and it shall — we cannot begin to apply the principle of prevention too early. Starting with prenatal care and early childhood immunizations, we must ensure that our nation's children arrive at school healthy and ready to learn. Likewise, we must apply the principle of prevention once children are in the schoolhouse as well.

Today, school-based health care is provided mostly at the middle or high school level. We have overlooked the critical role of our elementary schools. As a professional concerned with the interrelated educational and health outcomes of young children in the United States, you will find in this report a resource for thinking about the "what, why, and how" of elementary school-based health initiatives.

As with all efforts involving children, we must be vigilant to begin early both with health care and with health education efforts. Elementary school health can help sustain the gains of prenatal care and programs like Head Start to ensure that students are healthy and ready to learn to their fullest potential—ready to make the most of the tremendous opportunities elementary education offers.

Can we afford to wait to begin efforts fostering collaboration between the health and education sectors? No! And why? As has often been noted, we must act now because while children make up only 26 percent of our population today, they make up 100 percent of our future.

Patricia Hoven
Vice President and Executive Director
Honeywell Foundation

Foreword

Since 1990, the National Health & Education Consortium has worked to foster linkages between the health and education communities. This connection was seen as critical in promoting a healthy citizenry whose minds were receptive to learning and whose bodies would be sound for a lifetime. Elementary school children are one of the most important populations on which our efforts should be focused.

It is vital that these young children come to school mentally and physically ready to learn. School-based health centers represent a unique opportunity to identify and potentially address some of the problems that we know impact a child's ability to learn. We need to identify vision, hearing, nutritional, and other problems that impact a child's learning at the earliest possible age. And, to the extent possible, we need to address these problems quickly and comprehensively to enhance a child's ability to learn.

The National Health & Education Consortium hopes that *Starting Young: School-Based Health Centers at the Elementary Level* will provide you with the information that you need to promote or enable the provision of health services in the elementary schools in your community. It is at once a primer on elementary school-based health centers and an information resource on local, state and federal supports for elementary school health. The first section of the report answers the "what, how and why" of school-based centers to provide you with a better understanding of the history and rationale of placing health centers in elementary schools. This section will also help clarify how school-based health fits the academic mission of schools and how centers are funded and staffed.

The last sections of the report are resources regarding the range of supports at the local, state and national level for school-based and -linked health centers. They provide brief case studies, descriptions of model programs and legislation, and appropriate contacts for further information.

The last page of this publication is a tear-out response form for those of you desiring more detailed information. Please feel free to call on the National Health & Education Consortium to assist you in your efforts to ensure that the children in your community live long, happy and fulfilling lives.

Tamara Lucas Copeland

Tamara Lucas Copeland
Director
National Health & Education Consortium

Abstract

Starting Young: School-Based Health Centers at the Elementary Level is a resource for thinking about the "what, why and how" of elementary school-based or -linked health initiatives. It is at once a primer on school-based health centers and an information resource on local, state and federal support for elementary school health. *Starting Young* provides background, rationale, brief case studies, descriptions of model programs and legislation, and appropriate contacts for further information. It includes two graphs and a selected reading list. The table of contents on the next page provides a brief overview of the specific questions addressed by the report.

The main thrust of the publication is to help everyone concerned with the interrelated educational and health outcomes of children better understand the history and promise of, and concerns related to, school-based health centers at the elementary education level. Today, school-based health is provided mostly at the middle or high school level, overlooking the critical role of elementary schools.

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Starting Young:

School-Based Health Centers at the Elementary Level

The education and health care reform movements offer a window of opportunity for those who understand the tremendous potential of school health and the appropriate roles the school can play as an institution that touches the lives of young people, their families and the entire community. Until we are willing and able to undertake fundamental changes in our schools and communities to promote positive outcomes, we will continue to tinker at the margins of the health and educational attainment of our children

— Christopher DeGraw,
Senior Research Staff Scientist,
The George Washington University
Center for Health Policy Research[1]

Introduction

America's children are at risk: almost one in four babies is born without adequate prenatal care;[2] one in four children under age six lives in poverty;[3] children witness and are victimized by violence at younger and younger ages; children are increasingly having children of their own; and reports of child abuse and neglect continue to climb.[4] Too sick, tired, hungry and scared to learn, many children are coming to school unable to fully benefit from their educational experience.

Child health, of course, is not the only pressing public concern today. As George Kaplan has noted, "the common wisdom of the early 1990s holds that public education in America is in deep trouble."[5] One of public education's major challenges is coping with the health status — physical and mental — of its students and the impact of their health on their ability to learn. For decades educators and policy makers have discussed school and curriculum reform as vehicles for improving educational outcomes for our students. Increasingly, schools are acknowledging that education reform cannot occur without focusing on the other interrelated needs of families and children. Schools must commit themselves to both educating and helping build a foundation for learning.

One strategy schools have used to address children's complex and interdependent health, educational and social problems has been the implementation of school-based health centers. In 1984, 31 school-based clinics existed; by late 1992, more than 415 (and 95 school-linked) clinics existed in 42 states, the District of Columbia, Puerto Rico, and Guam.[6] This growth reflects not only the escalating demand for such services but also growing consensus that in our strained and

fragmented service delivery system, school-based centers are an effective and necessary mechanism for enabling children to be healthy and ready to learn.[7]

Interest in school-based health in general, and in elementary school-based programs in particular, has been fueled by calls from policy makers, health and education professionals and others for universal access to health care for all, but particularly for children. Most notably, the Clinton Administration indicated strong support for school-based and preventive services for children through its proposed health care reform package and the designation of school-based health clinic advocate Dr. Joycelyn Elders as Surgeon General. The number of state initiatives offering school-based health services in elementary schools has increased over the past decade, ranging in scope from small scale demonstrations and pilot projects to health centers offering preventive and primary health care. Although few in number, they have proven to improve the health and well being of young children.

Building on this momentum, the National Health & Education Consortium (NHEC) presents this report which is based on a 1992 nationwide feasibility study of elementary school-based health centers conducted by NHEC and The Conservation Company — a Philadelphia-based consulting firm specializing in not-for-profit enterprises. This study found that elementary school-based health centers can be a cost-effective strategy for addressing children's health and educational needs; that they can reach children and their families in a way most other community-based agencies and institutions cannot; and that the elementary school years are the time when active intervention can yield comprehensive, life long benefits for children.

Starting Young: School-Based Health Centers at the Elementary Level provides a context for the continuing evolution of elementary school-based health centers. It focuses on the local, state and federal level initiatives that either directly support such centers through legislation and funding, or indirectly support centers by creating an environment in which health, education and human service providers can collaborate more effectively.

This report is by no means meant to present an exhaustive listing of programs. It is not intended to measure the effectiveness of the initiatives described in the following pages, nor prescribe school-based health centers as the most appropriate model of health care delivery for every community. Instead, as the concept of elementary school-based health centers generates greater interest and momentum throughout the country, the intent of this document is to serve as a useful resource, a source of inspiration and a reference for learning from the successes and frustrations of others.

What are school-based health centers?

School health centers provide students with comprehensive primary medical, social and mental health services, delivered by multi-disciplinary teams of professionals, including nurse practitioners, physicians, social workers, nurses and educators[8] (see Graph 1) in or near the school building. Because school-based health centers focus on comprehensive health service delivery to children in school, they differ from common health support services (such as health screenings), comprehensive school health education programs, or projects where health is only a small component of a larger service integration initiative. There are two types of school health centers — those that are school-based and those that are school-linked. More specifically, the following definitions help distinguish between school-based and school-linked centers:[9]

School-Based Health Centers

A school-based health center (SBHC) is a health center located in a school or on school grounds that provides, at a minimum, on-site primary and preventive health care, mental health counseling,

health promotion, referral and follow-up services for young people enrolled. The key element is *location in a school*.

School-Linked Health Centers

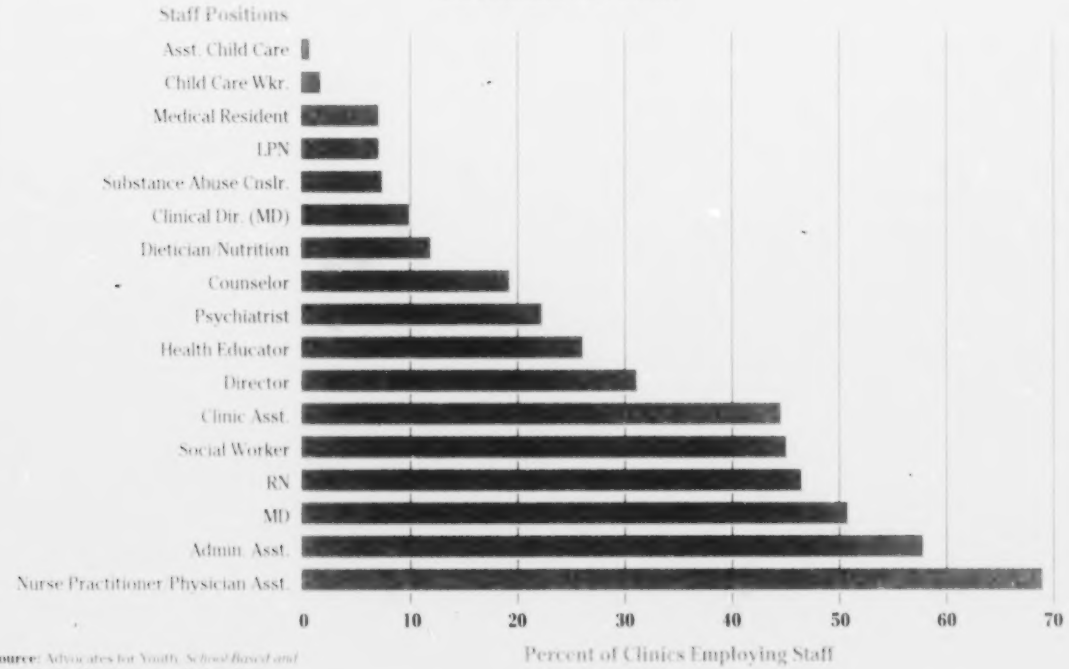
A school-linked health center (SLHC) is a health center located beyond school property that serves one or more schools. The center may also serve young people from the area who are not students. Services include, but are not limited to, primary health care screening and treatment, mental health counseling, health promotion, referral and follow up. The center usually has formal or informal ties to the schools — including accepting referrals from school personnel, providing priority appointments for students, marketing the services of the center in the school and/or offering classroom health education. A formal letter of agreement may or may not exist between the health center and the school. The key element is *location off school grounds*.

School-based health centers are part of a larger, ongoing "service integration" movement that has resulted in response to the current fragmentation of services for children. The centers themselves focus on health, education and social services working together more effectively, while service integration calls for coordinating and collaborating services so that the emphasis of each agency is shifted from itself to its clients: the child and the family.[10]

Why should health centers be placed in elementary schools?

Although there has been a growing proliferation of the school-based health center model of health care delivery, most school-based health centers are located in high schools and focus on adolescents. Yet educators, health practitioners and policy makers alike are now beginning to realize

Graph 1. **STAFFING OF SCHOOL HEALTH CLINICS**
School-Based and -Linked



Source: Advocates for Youth, *School-Based and School-Linked Health Centers, Update 1991*

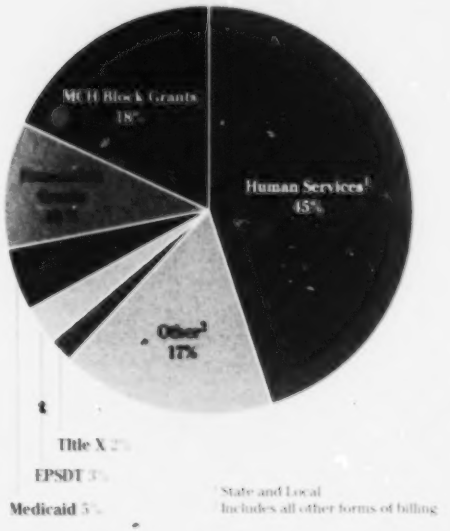
that we must turn our attention to younger children as well. The strategy of prevention requires that we start in the early years to ensure maximum benefit for students.

Statistics show that by the time students enter middle school, many have developed unhealthy habits and conditions that should have been addressed at a younger age. According to recent studies, the peak ages for initiation of cigarette smoking is in the sixth and seventh grade;[11] thirty-seven percent of eighth graders report having used alcohol by the end of the sixth grade;[12] and one out of every eight children under age 12 is hungry.[13] Placing health centers in elementary schools — which have demonstrated ability to reach young children *and* their families in the community, could alleviate the need for more costly and even stigmatizing services later on while simultaneously reinforcing the benefits and gains of early intervention programs such as Head Start and WIC.

How are school-based health centers funded?

Most school-based health centers are funded by a combination of private and public grants.[14] Private sources include organizations such as foundations and third-party reimbursements. The bulk of funding consists of public support such as state and local human and social service funds, Maternal and Child Health Block Grants, Medicaid, and a host of additional methods of billing for services (see Graph 2). Centers also rely on in-kind contributions to support their operation and services. A 1993 survey reported that, while school health centers have widely varying budgets — from less than $5,000 per year to more than $670,000 — the average annual budget was close to $170,000.[15]

Graph 2: **FUNDING SOURCES, 1991-1992**
School-Based Clinics



Source: Advocates for Youth, *School-Based and School-Linked Health Centers, Update 1993*

How do school-based health centers meet children's health and educational needs?

School-based health centers have been proven to help students access primary health care services and dental care. In addition, they provide information and education to students and families alike on critical health issues like immunizations, eating choices, smoking, drinking, and more. Similarly, school clinics often provide valuable mental health services. Clinics can also provide laboratory and pharmacy services in some cases. In this regard, school clinics help prevent problems related directly to school absenteeism, poor learning outcomes, truancy and, eventually, drop out. School health clinics can build partnerships between schools, families and community health providers, successfully reaching out to wide geographic areas; and have demonstrated a capacity to increase the numbers of children obtaining preventive services in school districts. In all cases, school clinics should be (and are) locally designed programs based on local needs.

The following brief case study of Harlem's Mount Sinai Pediatric School Health Program will provide a better understanding of how school-based centers operate and how they are begun. A number of case studies describing local school-based health initiatives are included in Appendix A to provide an in-depth reference tool for reviewing and contacting successful projects as the potential role of elementary school-based health centers is considered. Select adolescent health centers are included as well to provide additional ideas and comparisons.

MOUNT SINAI MEDICAL CENTER

Over 2,000 East Harlem children and adolescents in New York City receive basic health care from school-based health programs provided by Mount Sinai Medical Center. The program is part of a collaborative effort between Community School District Four, the New York State Department of Health, the Mount Sinai Medical Center and other local community health advocates to find practical solutions for the health and social problems of East Harlem children and their families.

The Mount Sinai Pediatric School Health Program has two major components: the Comprehensive Elementary School Health Clinic Project and the Early Child Health Project. Both were established in 1990. The Elementary School Clinic component serves more than 2,000 children through comprehensive pediatric clinics located in three elementary schools and one junior high school. School Health Clinic staff includes pediatricians, medical assistants, social workers, and health educators. Services include comprehensive physical examinations, immunizations, health screenings, and referrals to the Medical Center for secondary and tertiary care. On-site counseling and health education are also provided. The program is primarily funded by the New York State Department of Health, supplemented by support from the Medical Center and the Rose Family Foundation.

The Early Child Health Project is a school-based program providing intensive social services, mental health and child development evaluations, and on-site psychotherapy for high-risk young East Harlem children and their families. Intensive case management is provided by social workers who network with community agencies and the medical center. Staff for this project include several social workers, a medical assistant, and the services of a developmental pediatrician and a child psychiatrist. Funding is primarily provided by private foundations, including the Altman Foundation, New York Community Trust, Hasbro Children's Foundation, and others, with additional support provided by Mount Sinai. To meet an increasing level of need, the Early Child Health Project focuses on early identification and intervention for children with behavioral and developmental problems. Where possible, alternatives to special education are offered.

A third component of this comprehensive School Health Program began in September 1994. With funding from the Brookdale Foundation, Mount Sinai will provide a school-based comprehensive multi-generational health care and social service program for grandparents and other extended family members caring for their children's children. This innovative model will include school-based medical care for the adults and group counseling and support services.

Contact: Catherine Grimm
Chairman of Pediatric Ambulatory Care
Mt. Sinai Medical Center
One Gustave L. Levy Place
New York, NY 10029
(212) 241-0938

Will a health center detract from the school's primary function?

Few school-health advocates believe that schools or students will benefit from making the delivery of health and social services the sole responsibility of the schools themselves. Already often overburdened, teachers need help educating children, not additional pressures and regulations. That is exactly what elementary school-based health centers are designed to do: help teachers to teach by seeing that their sick, hungry or frightened students get the attention they need from qualified health experts to ensure that they return to the classroom faster and better able to learn.

In fact, the influential Committee for Economic Development — a national alliance of major corporate leaders — has stated explicitly and eloquently that:

> By both decision and default, much of the burden of dealing with a vast array of social problems has been placed on the public schools. Many look to the school instead of to parents and the community as the front line of defense against every social or health problem from teen pregnancy to child abuse, AIDS, violence and religious disaffection.
>
> No organization can traverse such a swamp of conflicting missions ... Community problems need to be addressed through community-driven services and institutions. These services may be *placed* in the schools, they may be *delivered* through the schools, but they should not be made the *responsibility* of the schools.[16]

Elementary school-based or school-linked health centers are an answer to this dilemma. They are a proven tool for forging a partnership between the school and the community to reach and help children toward the end of bettering their educational status. School clinics do *not* detract from the school's primary mission — learning — rather, they help protect it.

How do health care providers feel about school health centers?

While there will always be some disagreement of opinion among individual providers, most health care professionals seem to support the potential of school-based health centers. Certainly, many national health professional associations have come out in favor of the school health center model. It has been noted that "by the end of the 1980s, the American Academy of Pediatrics, the American Medical Association, the Society for Adolescent Medicine, the American School Health Association, the American Nurses Association, the National Association of Pediatric Nurse Practitioners, the National Association of School Nurses, and the National Association of State School Nurse Consultants had all adopted statements in support of the continued development of school-based health centers."[17] These sentiments are expressed on the local level as well. In a recent issue of *Pediatric News*, for example, clinic administrators interviewed for an article on school-based clinics indicated that "pediatricians in their communities generally welcomed the clinics, especially since most are located in medically underserved areas."[18] Some private practitioners, however, express concern that school-based health centers may not be sufficiently tied to existing community providers; may, on the other hand, duplicate services already available in the community; or may send an "inappropriate" message by implying, as one pediatrician has put it, "that if people don't go out and get health care, it will be brought to them."[19] Even so, on the whole, health care providers appear to be supportive of health centers in schools as uniquely successful avenues of early intervention and prevention that improve access to care.

What about family planning and sex education?

The issue of sexual activity counseling and reproductive services delivery has been a controversial one for school-based and -linked health centers for years. However, it is not a central issue at the elementary school level. Some advocates argue for early education about the risks of premature sexual activity and sexual abuse, and the need for acceptance of peers from non-traditional families; but, by and large, elementary school health initiatives are free of controversy regarding these issues. Communities tend to focus on the benefits of early intervention and health promotion activities at elementary schools, deferring their concerns over acceptable sex education and practice services to discussions of middle and high school initiatives.

When did school-based health centers begin?

The idea of providing health services to children in school is not a new one, but delivering comprehensive services on-site is. The history of school-based clinics is largely undocumented, but dates back to the origins of public education in the 1840s, when specialists debated whether or not to provide health services in the schools.[20] The debate was partially resolved in the 1890s, when health programs were introduced into the schools in response to the large numbers of immigrant children who, because of cramped and unsanitary living conditions, often came to school suffering from infectious diseases such as tuberculosis. Most of these early school health efforts concentrated on prevention. Mobile physician inspectors visited schools, focusing upon hygiene and occasional immunization.

School district physicians were eventually replaced by the more permanent presence of a school nurse. The role of the nurses varied from location to location, but, over the years, the presence of nurses in schools has become a standard feature in most school districts, demonstrating the degree to which educators have become dedicated to school health. Although in the past, direct treatment had been administered within schools, in the 1930s, schools began to sponsor a more limited program of health screening and first aid, relying on referrals to private settings for actual treatment. At this time, boards of education — not traditional medical institutions — controlled school health services.

Fueled by new concerns for student health in the 1960s, in 1970 the federally funded Children and Youth Project of the University of Texas Health Science Center Pediatrics Department began the first high school-based clinic. Following suit, in 1973, Dr. Laura Edwards and other members of the Maternal and Infant Care Project of the St. Paul Ramsey Hospital opened a comprehensive school-based health clinic in Mechanic Arts High School in St. Paul. This famous clinic was the first to provide comprehensive services that included family planning. When that school closed its doors, the clinic followed its students to two other schools, eventually expanding to two additional school sites as well.

By the late 1970s, the Robert Wood Johnson Foundation had begun a national school health program in elementary schools to document the feasibility of providing primary health care in the school setting. In 1986 the Foundation began funding 24 high school based centers through its "School-Based Adolescent Health Care Program." During the following years, the Foundation also funded nurse practitioner positions in schools in four states. Currently, the Foundation supports grants to 12 states through the nationally-recognized "Making the Grade" program.

Today more than 600 school-based and school-linked health centers are operating across the country,[21] and the number is growing each year.

For further history on the school-based health movement, NHEC recommends that you read Joy Dryfoos' book, *Full-Service Schools: A Revolution in Health and Social Services for Children, Youth and Families*, which is referenced at the end of this report.

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How has the government supported school-based health centers?

In addition to the local initiative described earlier (and those in Appendix A), both state and federal governments are making changes to support the design, implementation and evaluation of school-based health clinics.

State

There is, and has been, much more activity and leadership at the state than at the federal level to promote collaboration between the health and education sectors using schools as the focal point. Numerous jurisdictions are acknowledging that children are in desperate need of health care services and that schools can be an effective partner in delivering these services. However, the absence of adequate state and school district budgets has prevented the growth of school health services at a rate commensurate with the growing needs of our nation's children and youth.

Great differences exist among the level of services provided and the pace at which states are implementing school-based health centers, including those for elementary-age students. Some states, such as Arkansas and Connecticut, have promoted school-based health centers for students of all ages for quite a while, whereas others, like Massachusetts, are just recently expanding their school-based clinics to serve elementary-age students. Many state-level efforts are in the early stages of implementation. Virginia, for example, is in the process of establishing pilot school-based health centers.

Differences also exist in how states fund programs as well as the types of local level initiatives they promote. New York promotes school-based health centers with comprehensive on-site primary care, whereas New Jersey funds service integration programs which emphasize social services, recreation and job training. West Virginia initially promoted expanded school health programs through its Department of Education; more recently, its Department of Health has been funding school-based health centers in the state. The majority of states attempt to increase access through the enhancement of and/or linkages with existing services by expanding school nurse services and/or linking with community health centers to establish formal referral arrangements.

Stemming from the previously mentioned "Making the Grade" initiative, funded by the Robert Wood Johnson Foundation, we will likely see state-level activity surrounding school-based services increasing substantially in the coming years. Through the program, twelve states were recently selected to receive $100,000 grants to plan the delivery of, and reduce the barriers to, comprehensive school-based health services for school-age children. Up to 10 of the states will receive $2 million in 1995 to implement their plans. States that were chosen for the first phase of this $23.2 million program are: Colorado, Connecticut, Delaware, Hawaii, Louisiana, Maryland, New York, North Carolina, Oregon, Rhode Island, Tennessee and Vermont.

Appendix B provides examples of some of the nation's many state-level school-based health initiatives, including those targeted toward elementary school-age students.

Federal

During the 1980s, because of the widespread growth of school-based clinics in public high schools, school-based health services began to receive increasing national attention. On a federal level, reports, initiatives and legislation began to reflect these changing national attitudes. States and communities interested in establishing school-based health centers pieced together their services by creatively tapping into federal categorical funding programs, such as the Maternal and Child Health Block Grant, Community Health Center Funds, and Medicaid to supplement any other public and/or private support they may have had[22] (see Graph 2).

As the benefits of school health services have become more apparent in the 1990s and with the Administration's support of school-based and preventive services, the level of federal attention paid to school-based health centers has increased considerably. President Clinton included the funding of school-based health clinics as a possible service delivery mechanism in his proposed health care reform package and former Arkansas Health Department Director Dr. Joycelyn Elders was an outspoken advocate for school-based health care and health education as Surgeon General.

Furthermore, both the Departments of Education and Health and Human Services have expressed genuine interest in health issues as they relate to school systems and in fostering true cross-agency collaboration. In April 1994, the Secretaries of Education and Health and Human Services released a joint statement on school health, underscoring the cooperation between their Departments in efforts to improve the health of children (See Appendix E). Federal interagency committees have been established to examine school-based health promotion. For the first time, a federal grant from the Department of Health and Human Services specifically targets school-based and school-linked health center initiatives. This unprecedented top-level national leadership in support of school-based health services has resulted in sustained high profile visibility for such initiatives.

Although most federal attention has focused on adolescents, greater interest is arising in providing health services for younger children as well. A temporary shift in emphasis from adolescents to younger children was evidenced in a December 1991 report from the Advisory Council on Social Security recommending an appropriation of $6 million in federal money to establish school-based health clinics for children ages 3-12. More recently, Congressional committee markups of the President's health care reform proposal have resulted in proposing serving elementary school-age students in addition to adolescents through school-based health centers.

Appendix C provides recent examples of federal-level initiatives that address health and education collaboration, school-based health care in general, and the needs of elementary school-age students in particular. Because of the ever-changing landscape of federal health and education reform, a comprehensive summary of major federal legislative initiatives is not attempted here. However, some of 1994's major proposed national legislation most likely to directly affect the creation, maintenance and expansion of elementary school-based health clinics is addressed in Appendix D.

Conclusion

As the examples in these pages reflect, federal and state governments, as well as local communities nationwide, increasingly are poised to address a vital missing link in the provision of comprehensive, continuous quality care to children: elementary school-based health centers. As even a cursory overview of initiatives makes obvious, numerous differences exist between the various health support services offered in schools. Likewise, school-based health centers are just one of myriad ways to provide elementary school-age students with health care and information. The school-based health center is not the only model for a community and not all communities will need such a mechanism. But, they are often very effective and hold unique promise as a model to assist at-risk children. In addition, the health center model is increasingly finding support at the federal, state, and local governmental levels alike as well as from parents, the health community and the education community.

While federal legislation and programs specifically addressing elementary school-based health centers are still rare, federal interest in the issue of school-based health centers has grown considerably in recent years. States, for the most part, are ahead of the federal government in promoting school-based services at the elementary school level. Preventive and early intervention

approaches to children's health and education are gaining widespread support, and state-level programs are helping to guide federal activities in this area.

At the local level, some communities are turning to elementary schools to provide underserved children with the health and social services they need. Indeed, several locally designed elementary school-based health centers exist as "models" of care for the country. Nevertheless, the proportion of elementary school-based clinics to adolescent school-based clinics is still too low, and much work remains to be done to enhance access to care for all elementary school-age children, especially those younger students most at risk.

These trends suggest that government, communities and health and education professionals alike are acknowledging that growing numbers of children are in desperate need of health care services — and that schools can be a most effective partner in ensuring that they receive them. Moreover, it is increasingly clear that reaching children in elementary school, rather than waiting until they reach middle or high school, is vital to building on the benefits of early intervention programs and alleviating the need for more costly health and education services down the road. School-based health centers can serve as a crucial link in providing a continuous, integrated web of support services from pre-school through adolescence. These clinics can, in turn, help children reach their full learning potential by helping to ensure that their physical and mental health needs are being met as early as possible.

The Need for a National Focus on Elementary School Health

Responding to the need for awareness, action and coordination around school-based health at the elementary level, the National Health & Education Consortium (NHEC) and the Conservation Company, a Philadelphia-based consulting firm, have worked to build momentum at the national, state and local levels. As a first step, a national project, called the Elementary School-Based Health Initiative, was launched to promote the development, visibility and viability of elementary school-based health centers.

The project received planning support from the Prudential Foundation, the Robert Wood Johnson Foundation, the Graustein Memorial Fund, The Pew Charitable Trusts and the Kauffman Foundation. A number of new centers currently are under development in Kansas City, Missouri and the State of Connecticut.

The Initiative was designed to maximize access to health care for underserved and at-risk children, to improve their health behaviors and status, and to improve school performance.

Long-term needs remain. The nation sorely lacks mechanisms for accumulating evidence and data which make the case for ongoing and broadened national commitments to elementary school-based health. Likewise, there is a need for a national clearinghouse to synthesize and disseminate information about elementary school-based health, to build communication networks among existing centers, and to advance the creation of new ones.

Local Activities Supporting School-Based Health Centers

Recognizing that elementary schools often reach children and their families more effectively than other community-based agencies and institutions, communities increasingly are moving ahead to implement school-based clinics in their elementary schools. Locally designed elementary school-based clinics vary in scope and design. Some clinics, for example, operate as a community health center would, staffed by full-time physicians with back-up provided by the local hospital. Others have expanded the role of their school nurse and added staff and a visiting physician to provide primary care to their students. In some communities, elementary school-based clinics focus on health care as their primary priority, while in others social services are at the core. Following is an overview of some of the local-level elementary school-based health center initiatives underway in the United States.

Blackham Elementary School **(Bridgeport, CT)**: Located in an exceptionally poor area, Blackham Elementary School serves an ethnically diverse student population. Families at the school range from poor and near poor to the poorly insured. The elementary school and middle school has a nurse practitioner, social worker, part-time dentist and an outreach worker to meet the needs of enrolled students (880 of the schools' 1100 students). In its first year of operation, the Bridgeport Health Department-sponsored center provided direct services to nearly 600 students during some 3,000 visits. The elementary and high school centers provide similar care roughly 75 percent of the time, offering acute care, chronic care and mental health services. The elementary school boasts a staff outreach worker to help ensure home visiting, parent education and informal case management for specialty medical care or utilization of social services for the family. The clinic director notes that the elementary school health center sees more cases of contagious medical problems and fewer problems associated with risky personal behavior.

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Brennan's Health Connection **(New Haven, CT)**: This health center, located in the Katherine Brennan Elementary School, is one of two elementary school-based health centers funded through the MCH Bureau's "Healthy Tomorrows Partnership for Children." Additional funding comes from local foundations and the city health department. Services are currently rendered at no charge, but plans are to obtain Medicaid reimbursements in the future. The clinic was established through a collaborative effort between the New Haven Foundation, the principal of Brennan Elementary, and the City Departments of Health, Education and Community.

The clinic is staffed by a full-time pediatric nurse practitioner, a part-time school nurse, an outreach worker and a receptionist. A pediatrician consultant and a social work consultant join the staff for several hours each week and are available by phone at other times. In addition to providing on-site primary care, the clinic has established a referral mechanism with a nearby health center and a community hospital. The clinic is officially administered by the City Department of

Health and serves Head Start children, and infants and toddlers living in the neighborhood, in addition to Brennan's 460 students.

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Lynn Donahue, Nurse Practitioner, Clinic Manager
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Collaborative Leadership Council **(Ft. Worth, TX)**: As part of a community-wide collaborative initiative, a preventive health service delivery site was set up in 1992 at the S.S. Dillow Elementary School in Fort Worth. During the 1992-93 school year, an EPSDT screening program was established, with "clinics" held at the school one half day per week. These services are provided by Ft. Worth Public Health Department nurses, with outreach and administrative support from the school nurse. Due to the success of this pilot, services will be expanded at S.S. Dillow to five days per week, with a pediatric nurse practitioner providing additional services and referrals. Staff also include a health assistant, a Medicaid eligibility worker and a Licensed Vocational nurse. Services are available to students from two additional elementary schools in the neighborhood as well.

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Mya Coursey or T. Ware
Co-Facilitators
Collaborative Leadership Council
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Jackson-Hinds Comprehensive Health Center **(Jackson, MS):** The Jackson-Hinds Comprehensive Health Center is a community-based, primary health care program funded under Section 330 of the Public Health Service Act. To better serve at-risk school-age children, the Center has established primary health care clinics in four senior high schools, four junior high schools, one elementary school in the city of Jackson, and an elementary school in rural Hinds County.

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Jackson-Hinds Comprehensive Health Center
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Macon, GA: Macon is an example of a community moving toward the provision of comprehensive primary health care in its public elementary schools. Providers in Macon have begun this move with two initiatives.

"Schoolhouse Health," administered through the Medical Center of Central Georgia, focuses on the needs of the indigent community. With funding from the Georgia Indigent Care Program and supplies and equipment from the Medical Center, a pediatric clinical specialist was hired to work for one middle school and two elementary schools on a rotating basis. Backup services and referrals are provided by the Medical Center and its satellite neighborhood health care center. An expansion of the program is planned for the 1994-95 school year through use of indigent care trust fund monies and partnership with a local hospital. The Medical Center will eventually support three additional full-time nurse clinicians to serve a total of ten schools: one high school, one middle school and eight elementary schools.

The Bibb County Health Department is also sponsoring school-based health services. Currently, one registered nurse and a health technician serve two elementary schools on a full-time basis, performing on-site care and home visiting services. When school is not in session, the nurses work at neighborhood health clinics. In addition, mental health workers visit each school one half day per week for counseling. In the near future, the health department hopes to expand its program to involve additional elementary schools and assist middle schools.

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Administrator
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Macon, GA 31298
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Partners in Health (**Chicago, IL**): Coordinated through the College of Nursing, University of Illinois at Chicago (UIC), "Partners in Health" is primarily concerned with improving access to health care for elementary school students.

The program currently operates in four elementary schools in low-income, urban Chicago neighborhoods. Each site has hired two community residents and a nurse/coordinator to administer the program. In addition, each site has a pediatrician one half day per week. A three-year grant from the Robert Wood Johnson Foundation, along with funding from UIC, supports the project. The project is building networks with Chicago Public Schools and both city and state health departments to ensure future funding for the program.

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Roseland School District (**Santa Rosa, CA**): In 1990, three small school districts together established an elementary school-based health center to share. School nurses at each school site refer students to the clinic, which is run by a nurse practitioner. The clinic performs physical exams, immunizations and check-ups. Once a week, a mobile health unit, staffed by a physician, comes to the schools to provide treatment as well. The mobile unit also treats adults. However, service hours for the clinic and mobile unit are limited. The clinic operates using no new funds — a room was remodeled in the school, through district in-kind contributions and local doctors donated the equipment. Services are covered through state reimbursement and Medicaid dollars.

Contact: *Les Crawford, Superintendent*
Roseland School District
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San Jose School Health Centers (**San Jose, CA**): The San Jose Medical Center began establishing elementary school-based health centers five years ago, after starting two high school-based clinics earlier through the Robert Wood Johnson Foundation's School-Based Adolescent Health Care Program. Start-up money was raised from private foundations, and current funding comes from third-party reimbursements (Medicaid, EPSDT, etc.) as well as from state Proposition 99 funds (sales tax on tobacco). The San Jose School Health program currently operates four high school health centers, two elementary school programs, one middle school and three pre-school through 8th grade programs. All clinic staff are employed and insured by the San Jose Medical Center, and each clinic is licensed as an outpatient facility. Clinics are staffed by a nurse practitioner or physician's assistant, a medical assistant, a physician (one half day per week and on-call), a half-time case manager at three of the clinics, and donated time (students, interns and in-kind contributions).

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San Jose School Health Centers
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The Vaughan Street Family Center (**San Fernando, CA**): In September 1990, a "one-stop shopping" family center was opened at Vaughan Street Elementary School. This center offers access to a full range of health and social services and educational programs for both children and adults from the community. Services include dental care and immunizations in addition to a host of other offerings such as legal aid and housing assistance. The Los Angeles Educational Partnership (LAEP), an interagency collaborative group, is the convener and fiscal agent for the center. The center is administered locally by an independent

program commission, comprised of 50% parents and 50% service providers. Funding for the center comes from the United Way, a state "Healthy Start" grant, redirected school funds and in-kind volunteers.

Contact: *Yolanda Trevino, Director*
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West Dallas Children and Youth Project (**Dallas, TX**): This project evolved from a Title V federal grant dating back to 1967, when a local demonstration of health care delivery to underserved young people was set up at the University of Texas Southwestern Medical School. In 1972, after several interim revisions to the program, the Dallas Independent School District and the University of Texas Health Science Center at Dallas agreed to establish two health clinics for infants and school-age children on elementary school campuses. In 1989, the Community-Oriented Primary Care Program (COPC) was established by Parkland Memorial Hospital to consolidate existing community-based health services and to expand service access into communities where no services were present. The West Dallas Children and Youth Project became the first clinical service component of COPC.

The services offered by the clinics are extensive. The two elementary school-based health centers, at the Carver and Allen Elementary Schools, are staffed by interdisciplinary teams consisting of physicians, mid-level practitioners, social workers, case aides, medical assistants and clerical support staff. A pharmacy is also located on the premises, and dental services are provided at one of the clinics. The clinics are open year-round, and 24-hour back-up is provided by COPC. Approximately 70% of the children under age 19 in West Dallas utilize the clinics, making these true "community clinics."

Funding for the clinics comes from various sources, including the MCH "Healthy Tomorrows" program and MCH Block Grant, the Texas Department of Health, the Dallas County Hospital District, the United Way, Medicaid and EPSDT reimbursements, Title XX, patient fees, and miscellaneous donations. The Parkland Memorial Hospital administers and staffs the clinics; the Dallas Independent School District maintains the clinic sites.

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State Activities Supporting School-Based Health Centers

There has been a great deal of activity and leadership at the state level to promote collaboration between the health and education sectors using schools as the focal point. Numerous jurisdictions are acknowledging that children are in desperate need of health care services and that schools can be an effective partner in delivering these services. However, the absence of adequate state and school district budgets has prevented the growth of school health services at a rate commensurate with the growing needs of our nation's children and youth. Following is an overview of some of the innovative state-level efforts to promote elementary school-based health centers in the United States (some initiatives include an adolescent component).

SCHOOL-BASED HEALTH CENTER INITIATIVES

Arkansas:

The first school health initiative in Arkansas began in 1985 when a small community in western Arkansas requested that the Department of Health provide immunizations once a month to its students. Since then, the number of student service centers has grown and today clinics are serving the following schools: four are in elementary schools, five are in middle schools (including junior high schools), nine are in high schools, and four are serving schools that teach kindergarten through twelfth grade, inclusive. Although the types of services to be offered in schools are decided locally, services typically include health screening, counseling, immunizations, family planning, prenatal care, and health and family life education classes. Funding for these projects comes from state funds, MCH Block Grant money, Medicaid reimbursements and private foundations.

In September 1992, Arkansas received one of five CDC comprehensive school health grants. The grant outlines eight components of school health to be addressed: nutrition services, playground safety, school health services, health education, physical education, teacher training, counseling and psychological services, and parent and community involvement.

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Colorado:

School-based health centers in Colorado represent strong local interagency collaboration, with multiple agencies co-locating staff in schools where services are accessible to vulnerable populations. Beginning in the late 1970s, school-based and school-linked health centers began operating in the rural San Luis Valley Area and in the urban Commerce City area of Colorado. In 1988, three high school programs were started in Denver. Because of their successes, in 1993 Denver began expanding them into new high school, middle school and elementary school sites. Currently there are 17 school-based health center sites located in five different Colorado communities. Centers offer primary and preventive health services. They are supported by a wide variety of funding sources including:

the Maternal and Child Health Block Grant; the Bureau of Primary Health Care; the Substance Abuse Block Grant; local city funds; Medicaid; and private grants.

Interest in the school-based health center model continues to grow in Colorado. A Governor's Statewide Conference last year drew 350 participants from around the state. In early 1994, the Colorado Department of Health received a 15-month award from the Robert Wood Johnson Foundation to plan new school-based health centers, and to identify and overcome policy and financial barriers to replication of this innovative model. Approximately 45 communities have indicated that they are interested in participating in the initiative.

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Colorado School-Based Health Center Initiative
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Connecticut:

In 1984, the Connecticut Department of Health Services (now the Department of Public Health and Addiction Services) began funding a part-time School-Based Health Center in a high school in Bridgeport with approximately $50,000 of MCH Block Grant funds. In 1985, the Department sought funding through legislative appropriations to begin building a state-wide system of programs. Over the past nine years, the program has grown to its present 29 sites and will increase sites by January 1, 1995. The budget has also increased to nearly $3 million, including state appropriations, MCH Block Grant dollars and a small amount of Drug-Free School and Communities Act funds. School-based health centers are located in eleven districts, with additional districts to be added in 1995 and offer primary and preventive health care as well as mental health and social services. Of the 29 sites, 13 centers are located in high schools, seven are in junior high and middle schools, eight are in elementary schools, and one is in an early child development center.

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Massachusetts:

In 1987, the Massachusetts Department of Public Health offered to provide technical assistance to communities interested in starting school-based health centers with local funds. Beginning in 1989, the Department began using $144,000 in MCH Block Grant dollars to fund new and existing community school-based health center initiatives, increasing that amount to $410,000 the following year. In November 1992, the voters of Massachusetts approved a referendum which added a 25 cent tax on cigarettes. In FY95, $2.6 million of this revenue is being used to fund school-based health centers at 32 school sites: 23 in high schools; three in elementary schools, K-6; three in elementary/middle schools, K-8; and three in middle schools, 6 (or 7) - 8. The centers offer primary care, coordinate with health education and existing school health activities, and link to community-based services for youth and their families.

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New York:

In 1978, Robert Wood Johnson Foundation monies became available for school-based primary care demonstration projects in schools serving children K-12. In that same year, the state of New York passed legislation that allowed nurse practitioners to deliver primary health care services and gave them prescription privileges. In response, the Department of Education began expanded school health services programs in eight school districts, primarily in upstate New York. Since state funding was not made available through the Department of Education, in the early 1980s responsibility was given to the Department of Health for further development of school-based primary health care. State funding for school-based health services was provided to community health care providers such as hospitals, community health centers, and health departments to provide health care in schools. School-based health centers serve children K-12 and are currently funded through a variety of sources including Medicaid, MCH Block Grant and state dollars. Most activity is concentrated in New

York City, where nearly 100 school-based health centers are currently operating. In 1993, more than 186,000 client visits were made to authorized school-based clinics.

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School State Health Program
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Pennsylvania:

In 1992, the Pennsylvania Departments of Health and Education collaboratively issued a Request For Applications to establish school-based health centers in six high need areas of the state. In early 1993, three rural and three urban school districts received funds to establish health centers in one or more elementary school buildings. These School-Based Primary Health Center Pilot Projects are funded through a combination of state funds and federal MCH Block Grant funds ($400,000 for calendar year 1993). The projects are funded for a three year period to provide on-site primary services to children including the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) screenings, physical examinations, health education, treatment of minor acute health problems and conditions, and referral and tracking for health problems requiring specialized services.

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Texas:

In February 1993, the Bureau of Women and Children of the Texas Department of Health (TDH) released the first of two Requests For Proposals to provide school-based comprehensive preventive and primary care for medically underserved children in Texas. Using MCH Block Grant monies, the School Health Program at the TDH funded eight school-based health center projects in August 1993, and an additional eight projects in June 1994.

Among the requirements to be eligible for TDH funds, a community had to form a local school health advisory council to participate in the planning and operation of the school-based health center. Proposals reflected collaborative planning among school administrators and personnel (including school nurses), school families, mental health counselors, members of the community, and local providers of health care so as to address the specific health problems of children in the community.

The school-based health center projects currently funded include a variety of models serving 34 elementary schools, in addition to other middle schools, high schools and one alternative school. Although varying slightly from project to project, the core staff of the health centers is usually comprised of a physician and/or nurse practitioner, a mental health counselor, a social worker, a registered nurse, and a clerk/secretary.

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Service Integration Initiatives

California

The *Healthy Start Support Services for Children Act*, authorized by SB 620 (Chapter 759, California Statutes of 1991) is California's first statewide effort to place comprehensive support services at or near schools. The initiative's objective is to provide prevention-oriented integrated health, mental health, social, educational and other support services to children, youth and families.

Since *Healthy Start* was first implemented in 1992, approximately $20 million has been authorized annually for planning and operation grants to school districts and county offices of education on behalf of eligible schools and their community partners. During its first three years, *Healthy Start* funding provided for 112 operational grants and 227 planning grants that involve elementary, middle and high schools in urban and rural areas throughout the state. Schools form collaborative partnerships with public agencies, community-based organizations, and other local agencies that serve children and families to govern and carry out the initiative. While some direct services are provided at the school site, *Healthy Start* collaboratives also provide systems of referral to community agencies.

The *Healthy Start* initiative is the cornerstone of California's "Partnership for Comprehensive Integrated School-Linked Services." Members of the partnership include the Governor's Office, the Superintendent of Public Instruction, 15 California foundations, and a variety of state departments, including Health, Mental Health, Social Services, and Alcohol and Drug Abuse Programs.

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Florida

As a result of an Interagency Agreement signed in 1990 by the Florida Education Commissioner and the Florida Secretary of Health and Rehabilitative Services, several school health initiatives have been undertaken. The policy initiative most resembling elementary school-based clinics is the *Supplemental School Health Services Act of 1990*. The Act enables county public health units, in conjunction with school districts, to develop and implement supplemental school health services projects. The program enables a total of 222 schools, 94 of which are elementary schools, to offer primary health care and health promotion. The number of participant schools will increase as legislative appropriations and other funding becomes available. In 1990, the "Full Service School" initiative was created to incorporate a variety of services into the school environment, including health and social services. The program operated in 162 schools during the 1993-1994 school year, and participation is expected to increase in the future. Florida's approach to integrating health and social services at school sites has also included a capital outlay program to facilitate service delivery. The capital outlay program has invested $59 million over four years in renovation, remodeling, new construction and equipping the facilities that house school-based health and social services programs and personnel.

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Kentucky

Section 18 of Kentucky's Education Reform Act of 1990 mandates the establishment of *Family Resource and Youth Services Centers* across the state. An Interagency Task Force has developed a five-year implementation plan for this initiative. Schools in which at least 20 percent of the student body are eligible for the National School Lunch Program can participate. By 1997, all eligible Kentucky public schools will be served by Centers.

Family Resource Centers, based on Edward Zigler's "Schools of the 21st Century" model, focus on elementary-aged children and their families and provide assistance with pre-school child care and after school child care, parent education, and health services. Youth Services Centers, which are modeled on New Jersey's School-Based Youth Services Program *(see below)*, work with middle school, junior high and/or high school students and their families; combined grade level centers are also permitted. Centers must be located in or near a school and provide referrals to health and social services; employment counseling, training, and placement for youth; job development; substance abuse services and referrals; and family crisis and mental health services or referrals. Currently, there are over 400 established centers.

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New Jersey

The State Department of Human Services (DHS) operates the *School-Based Youth Services Program (SBYS)* which offers health and social services to adolescents and children in areas of need throughout the state to facilitate obtaining their educational potential and leading mentally and physically healthy lives. In its first 1987-1991 phase, $6 million was provided by the Department to establish 29 sites for adolescents in secondary schools. A 25% local match requirement was met through in-kind services or direct contributions. In fiscal year 1991, an additional $500,000 was provided to develop pilot sites in middle and elementary schools.

The first two elementary school level programs funded through SBYS are located in New Brunswick and Bridgeton. All eight elementary schools in New Brunswick participate in the SBYS program. Services include referral to and delivery of primary and mental health care, as well as academic assistance, employment counseling for parents and social and recreational activities. Downe Township Elementary School and Bridgeton Middle School in Bridgeton, whose programs are managed by community-based agencies, provide comprehensive health and social services to their students.

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Expanded School Health Services

Virginia

The Virginia General Assembly designated $1.5 million for the establishment of 12 two-year pilot school community health center programs to be administered by the Departments of Education and Medical Assistance Services (Medicaid). All grantee school districts are required to be or become Medicaid providers and to bill for the provision of health-related services. The state encourages sites to become qualified to provide services under the EPSDT program, thus enhancing the Medicaid funding source. Applicants developed proposals based on one of three delivery models: (1) screening and referral by school nurses; (2) nurse practitioners providing primary care; or (3) school-based centers. Pilot sites must determine how services will continue once grant funding ceases.

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804/225-2671

West Virginia

West Virginia has several unique partnerships that allow for delivery of expanded health services to elementary age children. In Hardy County, the E.A. Hawse Primary Care Center provides school-based health services at two elementary schools one or two mornings a week. In Lincoln County, the Lincoln County Primary Care Center has entered into a partnership with the school nurse and the school system. The school nurse determines students who are in need of physical exams, does the initial screening including vision, hearing, blood pressure, etc. and then schedules the students for the physical exam on a day when staff from the Lincoln Primary Care Center are available to come to the school. The primary care center bills Medicaid or private providers and splits the payments received with the school system. The school then uses these dollars to expand their delivery of a comprehensive school health program.

Contact: *Lenore Zedosky, Director*
Healthy Schools Program
West Virginia Department of Education
Building 6, Room 309
1900 Kanawha Boulevard East
Charleston, WV 25305-0330
304/558-8830

Federal Activities Supporting School-Based Health Centers

At the federal level, reports, initiatives and legislation have begun to reflect the nation's changing attitudes about the importance of school-based and school-linked health initiatives. Although most federal attention has focused on adolescents, greater interest is arising in providing health services for younger children as well. Following is an overview of efforts by the federal government to support the growing school-based health movement.

Federal Departmental and Programmatic Initiatives

Federal Reports

The federal government has issued several reports that focus on children's health and the role of school-based health services. In June 1991, for example, the U.S. Office of Technology Assessment (OTA), a Congressional support agency, released a report on adolescent health care that endorses school-based health clinics as an effective intervention mechanism.[23] As indicated earlier, a December 1991 report from the Advisory Council on Social Security, also known as the "Steelman Commission," recommended an appropriation of $6 million in federal money to establish school-based health clinics for children ages 3-12.[24] In December 1993, the Department of Health and Human Service's Office of the Inspector General issued a report called "School-Based Health Centers and Managed Care" which describes the degree of coordination between school-based health centers and managed care providers.[25] A few months later, in May 1994, the United States General Accounting Office (GAO) released "School-Based Health Centers Can Promote Access to Care," a study examining access issues of school-based health centers.[26]

Federal Committee Initiatives

In addition to federal reports, the U.S. Departments of Education and Health and Human Services have established three complementary interagency committees to examine and facilitate school-based health promotion and service delivery. *For further information on these activities, contact Kristine McCoy, Coordinator, School Health Programs, Office of Disease Prevention & Health Promotion, U.S. Department of Health and Human Services, 202/205-8180.*

- **Ad Hoc Committee on Health Promotion Through the Schools:** Begun in 1983, the Committee convenes federal agency staff to promote communication between federal offices and agencies with programs related to school health.

  In 1992, the Committee published *Healthy Schools: A Directory of Federal Programs and Activities Related to Health Promotion Through the Schools.* This publication provides information on more than 100 federal programs related to school health and is available from: *National Health Information Center, P.O. Box 1133, Washington, D.C. 20013-1133, 800/336-4797.*

- **Interagency Committee on School Health (ICSH)**: Begun in June 1992 and co-chaired by assistant secretaries of the Departments of Education and Health and Human Services, the Committee consists of more than forty high-level representatives from nine federal departments and agencies. The Committee is concerned with all federal programs related to the promotion and implementation of school health programs. ICSH has three subcommittees: Integrated Services, Curriculum, and Health Services.

- **National Coordinating Committee on School Health (NCCSH)**: Begun in April 1993, this Committee brings together leaders from national nongovernmental health and education organizations, as well as the Departments of Education and Health and Human Services, to facilitate communication, collaboration, and support for comprehensive school health programs in public schools. The NCCSH serves in an informal advisory capacity to the Interagency Committee on School Health.

Federal Funding Initiatives

In May 1994, the U.S. Department of Health and Human Services' Maternal and Child Health Bureau (MCHB) and the Bureau of Primary Health Care (BPHC) issued the first federal grant program targeted specifically at school-based health centers. The **Healthy Schools, Healthy Communities Initiative** provides $5.75 million to fund school-based services for the homeless and at-risk students. Under this initiative, $3.25 million is available for funding school-based primary health care services; $1 million is for health education promotion services provided through school-based health centers; and $1.5 million for school staff health development grants. Approximately 15 grants will be issued to set-up or expand primary care services at existing sites. The grant program does not limit the age-range of the children to be targeted.

The Bureau of Primary Health Care of the U.S. Department of Health and Human Services runs another initiative that currently supports school-linked and school-based clinics through approximately 200 of the Community and Migrant Health Centers funded through Sections 329 and 330 of the Public Health Service Act. In 1993, it awarded three administrative supplements to demonstrate violence prevention and mental health promotion in school-based clinics. The Bureau has published a directory of its school-based and school-linked clinics and has conducted a best practices study entitled "School-Based Clinics That Work." *For more information, contact Jane Martin, Division of Programs for Special Populations, Bureau of Primary Health Care, 301/594-4470.*

In addition, through grant programs not directly targeted for school-based health centers, but certainly not exclusionary of them, the MCHB administers several other collaborative initiatives. The **Community Integrated Services System** (CISS) grant program, for instance, seeks to reduce infant mortality and improve the health of mothers and children through the development and expansion of community integrated service systems. These systems are public/private partnerships of community health and other organizations and individuals working collaboratively to address community health problems. During 1992, the first year of the program, 32 grants were awarded for a four-year project period. In 1993, nine grants were awarded for a four-year project period. Currently there are 41 active grants. *For further information, contact Joe Zogby, Division of Infant and Child Health, MCH, 301/443-6600.*

The **Healthy Tomorrows Partnership for Children** is a collaborative program between MCHB and the American Academy of Pediatrics that provides five-year grants to support special projects that demonstrate how states, local agencies, organizations, businesses, and communities can work together to improve access to services for children and adolescents. Currently, Healthy Tomorrows has funded 64 programs nationally, including at least 12 different programs involving school-related services (*see, for example, "Brennan Health Connection" in "Local Initiatives" section*). *For further information, contact the program director, Latricia C. Robertson, 301/443-3163.*

In addition, MCHB provides block grants to states to improve the health of and assure access to health services for mothers, infants, children, adolescents, children with special health care needs, and their families. The MCHB currently comprises a major source of funding for school-based health center efforts. Approximately half of all states use the MCH block grant to fund school health services. *For further information, contact the MCH office of your state health department.*

Federal Legislative Initiatives

In 1992, with a new President in the White House, a First Lady focused on health care, a child advocate Surgeon General, and a Congress infused with a record

number of new Members committed to health care reform, many believed that federal legislative activity addressing integrated and school-based services would be substantial in the coming years. By 1993, health care reform had already taken center stage, and the inclusion of funds for school health services in the President's "Health Security Act of 1993" proposal fueled interest in school health services. Education reform, through the re-authorization of the Elementary and Secondary Education Act (ESEA) and the recently legislated "Goals 2000: Educate America Act" is likewise expected to promote linkages between the nation's schools and health and social service agencies. In addition, several proposed bills in 1994 signaled the trend toward promoting school-based health (see Appendix D). While broad-based consensus on the scope of such reform is far from becoming a reality, proposals ranging from incremental tinkering to complete systemic restructuring are driving the Congress toward some kind of meaningful action affecting what new opportunities will emerge for the coordination of services for children.

"Health Security Act of 1993"

President Clinton's health care reform package, the "Health Security Act of 1993" was the most visible bill addressing school-based health services. As part of the package, the school-based and school-related health services program requested substantial funds to establish grant programs to provide school-based, school-linked, or other community-based health services to adolescents and school-age youth. Although priority would be given to grant programs focusing on 10-19 year-olds, services are not limited exclusively to that age-range.

The Clinton Health Security Act spurred Congressional interest surrounding school-based health centers. Both the House and the Senate were discussing committee alternatives to the Administration's health care reform proposal at the end of the 103rd Congress' session. The Senate Labor and Human Resources and the House Education and Labor Committees, for example, expanded the school health services piece in the Health Security Act to include children younger than 10 years of age. The Senate version of the bill proposed that health services be offered to children ages 4-19; whereas the House version targets children 3-21 for such services.

Of course, the future of health care reform is unknown, and eventual legislation may range widely in terms of its implications for children and school-based or -linked health services. One thing, however, is clear: the issue of health care for school-aged children is building a constituency at the federal level and will be an important part of health care discussions for the foreseeable future.

Elementary and Secondary Education Act (ESEA)

Among the most important legislative action was the recent re-authorization of the Elementary and Secondary Education Act (ESEA), called the *Improving America's Schools Act*. Most significant of ESEA's provisions is its Chapter 1 — or Title I — program, which provides federal funds to help school districts improve instructional programs and educational outcomes for educationally disadvantaged children. The program focuses on low-income children, and its funding formula targets resources to schools located in areas with high concentrations of child poverty. In addition, for the first time, the *Improving America's Schools Act* makes a percentage of the funds received under the Act available for the establishment and implementation of coordinated services projects. Planning and implementation of these projects are designed to encourage a comprehensive approach to meeting educational, health, social service and other needs of children and their families through community-wide partnerships that link public and private agencies through a coordination site at or near a school.

National Education Goals

On March 31, 1994 President Clinton signed into law the *Goals 2000: Educate America Act*. *Goals 2000* calls on states to "incorporate strategies for providing students and families with coordinated access to appropriate social services, health care, nutrition and child care to remove barriers to learning and enhance school readiness for all students." In order to receive funds under the bill, state educational agencies are required to demonstrate how they will develop comprehensive strategies to involve health and human services agencies that serve children in meeting educational standards.

Major 1994 Proposed Federal Legislation

Comprehensive Services for Youth Act (H.R. 1022), sponsored by Representative Maxine Waters, would authorize the Department of Health and Human Services to award grants to community partnerships to coordinate and deliver comprehensive education, health and social services to children or youth in school-based, school-linked or community-based health centers. Low-income communities with youth who lack access to health care and show problem behaviors would be targeted.

The Link-Up for Learning Act (S. 98 and H.R. 520), sponsored in the Senate by Senator Bill Bradley (D-NJ) and in the House by Representative Nita Lowey (D-NY), would authorize the Department of Education to award grants to local school systems receiving funds from Chapter 1 to coordinate school-based or community-based educational support services, including health and mental health services, among others.

Neighborhood Schools Improvement Act (H.R. 92), introduced by Representative Dale Celt. Under the bill, local education agencies (LEAs) would receive subgrants to establish broadly representative committees to develop and oversee the implementation of local plans. These LEAs would be allowed to allocate funds for coordinating health and social service activities with education efforts.

Healthy Students-Healthy Schools Act (S. 629; H.R. 1439), sponsored in the Senate by Senator Jeff Bingaman (D-NM) and in the House by Representative Michael Andrews (D-TX). The legislation would establish a "Healthy Students-Healthy Schools" office in the federal Centers for Disease Control and Prevention (CDC) and create a national "Healthy Students-Healthy Schools" advisory council to review, coordinate and streamline federal health education efforts. The measure would also ensure that the Department of Education's drug-free schools money could be used in conjunction with comprehensive school health programs.

Joint Statement on School Health by the Secretaries of Education and Health and Human Services

Health and education are joined in fundamental ways with each other and with the destinies of the Nation's children. Because of our national leadership responsibilities for education and health, we have initiated unprecedented cooperative efforts between our Departments. In support of comprehensive school health programs, we affirm the following:

America's children face many compelling educational and health and developmental challenges that affect their lives and their futures.

These challenges include poor levels of achievement; unacceptably high drop-out rates; low literacy; violence; drug abuse; preventable injuries; physical and mental illness; developmental disabilities; and sexual activity resulting in sexually transmitted diseases, including HIV, and unintended pregnancy. These facts demand a reassessment of the contributions of education and health programs in safeguarding our children's present lives and preparing them for productive, responsible, and fulfilling futures.

To help children meet these challenges, education and health must be linked in partnership.

Schools are the only public institutions that touch nearly every young person in this country. Schools have a unique opportunity to affect the lives of children and their families, but they cannot address all of our children's needs alone. Health, education, and human service programs must be integrated, and schools must have the support of public and private health care providers, communities and families.

School health programs support the education process, integrate services for disadvantaged and disabled children, and improve children's health prospects.

Through school health programs, children and their families can develop the knowledge, attitudes, beliefs, and behaviors necessary to remain healthy and perform well in school. These learning environments enhance safety, nutrition, and disease prevention; encourage exercise and fitness; support healthy physical, mental, and emotional development; promote abstinence and prevent sexual behaviors that result in HIV infection, other sexually transmitted diseases, and unintended pregnancy; discourage use of illegal drugs, alcohol, and tobacco; and help young people develop problem-solving and decision-making skills.

Reforms in health care and in education offer opportunities to forge partnerships needed for our children in the 1990s.

The benefits of integrated health and education services can be achieved by working together to create a "seamless" network of services, both through the school setting and through linkages with other community resources.

Goals 2000 *and* Healthy People 2000 *provide complementary visions that, together, can support our joint efforts in pursuit of a healthier, better educated Nation for the next century.*

Goals 2000 challenges us to ensure that all children arrive at school ready to learn; to increase the high school graduation rate; to achieve basic subject matter competencies; to achieve universal adult literacy; and to ensure that school environments are safe, disciplined, and drug free. *Healthy People 2000* challenges us to increase the span of healthy life for the American people, to reduce and finally to eliminate health disparities among population groups, and to ensure access to services for all Americans.

In support of *Goals 2000* and *Healthy People 2000*, we have established the Interagency Committee on School Health co-chaired by the Assistant Secretary for Elementary and Secondary Education and the Assistant Secretary for Health, and we have convened the National Coordinating Committee on School Health to bring together representatives of major national education and health organizations to work with us.

We call upon professionals in the fields of education and health and concerned citizens across the Nation to join with us in a renewed effort and a reaffirmation of our mutual responsibility to our Nation's children.

Richard W. Riley
Secretary of Education

Donna E. Shalala
Secretary of Health and Human Services

NHEC OVERVIEW

The health and education of children are intricately linked. Yet, for a variety of historical and societal reasons, these two critical facets of children's development have been separated. As a result, society finds itself either concerned about the "health" of children or the "education" of children, but is all-too-rarely aware of how the two fields are interdependent.

In 1990, in recognition of the need for better integration of health and education programs for children in this country, the National Health & Education Consortium was established by the National Commission to Prevent Infant Mortality (NCPIM) and the Institute for Educational Leadership (IEL) with core financial support from the Prudential Foundation. As a result of this special partnership, NHEC, from its inception, was a public/private partnership grounded in both the education and health communities.

NHEC now brings together 58 national health and education professional member associations, representing some 12 million constituents, to design strategies to better coordinate health and education services and programs. It does not represent any particular special interest group, but uniquely can mobilize the collective influence of national membership associations on behalf of its mission.

The National Health & Education Consortium contends that children must be healthy to be able to learn, and that they must be educated to keep themselves healthy for a lifetime. Millions of infants and children lack access to health care or suffer from poor health, leaving them vulnerable to physical and learning problems. And, far too often, information on how to maintain a healthy lifestyle does not reach those in greatest need. Coordination of health and education services for children can enhance their ability to learn, succeed in school and become productive members of society.

NHEC's goals are:

- to improve public policy by addressing the need for a better coordinated health and education delivery system;
- to strengthen communication and dissemination of information between health and education practitioners and policymakers; and,
- to identify exemplary program models and practices which more effectively integrate health and education services.

To accomplish its mission, NHEC produces occasional papers, special reports and major research documents focused on various topics relating to collaboration between the health and education communities. NHEC also provides training and technical assistance to federal, state and local leaders to promote collaborative efforts at all levels of government and in the private sector, and operates a number of special programs.

National Health & Education Consortium Members

American Academy of Family Physicians: represents 71,000 physicians

American Academy of Pediatrics: represents 45,000 pediatricians

American Association of Colleges for Teacher Education: represents 706 Member Institutions' teacher education programs

American Association of School Administrators: represents 18,517 school administrators

American College of Nurse-Midwives: represents 3,500 practicing nurse-midwives

American College of Obstetricians and Gynecologists: represents 31,000 obstetricians and gynecologists

American Dental Association: represents 140,000 dentists

American Federation of Teachers: represents 750,000 teachers, para-professionals (teacher aides), school-related personnel, health-care workers, federal and state employees

American Hospital Association: represents 5,870 hospitals and over 50,000 physicians

American Indian Health Care Association: represents 36 programs and clinics which focus on the health care of American Indians

American Medical Association: represents 300,000 physicians

American Nurses Association: represents 201,000 registered nurses

American Psychological Association:represents 118,000 clinicians, researchers, educators, consultants and students

American Public Health Association: represents 30,977 physicians, nurses, therapists, health technicians, health support personnel, and other health professionals

American School Food Service Association: represents 65,000 child nutrition and school food service employees

American School Health Association: represents 4,100 health educators, nurses, physicians and dieticians

American Speech-Language-Hearing Association: represents 74,000 audiologists and speech-language pathologists

Association for the Care of Children's Health: represents 4,200 nurses, Child Life workers, and parent leaders

Association for Supervision and Curriculum Development: represents 153,000 teachers, school administrators, college professors and school board members

Association of American Medical Colleges: represents 126 U.S. medical schools, 450 teaching hospitals, and 94 academic professional societies

Association of Maternal and Child Health Programs: represents 269 Maternal and Child Health Program directors and staff

Association of Schools of Public Health: represents 14,500 faculty and students at 26 certified schools of public health

Association of State and Territorial Dental Directors: represents 44 state dental directors nationwide

Association of State and Territorial Health Officials: represents 58 health officers from each of the United States and its territories

Association of Women's Health, Obstetric and Neonatal Nurses: represents 24,700 nurses

Council of Chief State School Officers: represents 56 public officials who head departments of elementary and secondary education in each state and extrastate jurisdiction

Council of the Great City Schools: represents 47 of the largest urban public school districts in the United States

Healthy Mothers, Healthy Babies Coalition: represents 95 non-profit health education groups, and state and local education groups

National Alliance of Black School Educators: represents 4,000 African-American teachers for grades K-12

National Association for Asian & Pacific American Education: represents approximately 500 educators concerned for the educational well-being of Asian and Pacific American students

National Association for the Education of Young Children: represents nearly 77,000 professionals and others who study or are interested in childhood education and development

National Association of Children's Hospitals and Related Institutions: represents 108 hospitals

National Association of Community Health Centers: represents 600 health care facilities

National Association of Elementary School Principals: represents 26,000 elementary and middle school principals in the United States, Canada and overseas

National Association of Hispanic Nurses: represents 1,000 Hispanic nurses

National Association of Partners in Education: represents 5,500 volunteers, presidents and executives of private businesses, teachers and administrators

National Association of Pediatric Nurse Associates and Practitioners: represents 4,200 pediatric nurse associates and practitioners

National Association of School Nurses, Inc.: represents 8,000 school nurses

National Association of Secondary School Principals: represents 41,000 secondary school principals, administrators, guidance counselors, activities directors and college professors

National Association of Social Workers, Inc.: represents 145,000 professionals and para-professionals in the field of social work

National Association of State Boards of Education: represents 600 state boards of education and their members

National Association of State School Nurse Consultants: represents over 20,000 school nurses in 12,000 school districts with responsibility for comprehensive school health services programs

National Association of WIC Directors: represents 624 state directors, nutrition coordinators, and local agency directors

National Black Nurses' Association: represents 7,000 African-American nurses

National Coalition of Hispanic Health and Human Services Organizations (COSSMHO): represents 12,000 organizations serving the Hispanic population, representing Hispanic physicians, nurses and students

National Community Education Association: represents 1,550 teachers, superintendents, administrators, community education directors and coordinators, faculty and administrators of teacher education institutions and programs, community activists, private businesses and state administrators

National Education Association: represents 2.1 million K-12 classroom teachers, professors, educational support personnel and students

National Head Start Association: represents 5,000 professionals working with Head Start programs nationwide

National Indian Education Association: represents 2,700 individuals dedicated to promoting quality education for American Indian and Alaskan Native people

National Medical Association: represents 16,500 primarily African-American minority physicians

National Mental Health Association: represents 450 local affiliate mental health associations, comprised of mental health care providers and clients, and community mental health centers

National Perinatal Association: represents 2,500 physicians, nurses, nurse-midwives, social workers and consumers of perinatal services

National PTA (National Congress of Parents and Teachers): represents 6.8 million parents, K-12 classroom teachers, principals, school administrators and students

National Rural Health Association: represents 2,000 community, migrant and homeless health centers and their staffs

National School Boards Association: represents 52 state school board associations

National School Public Relations Association: represents 2,200 teachers, principals, administrators, retired teachers, students and public relations personnel

Society for Neuroscience: represents 21,219 neuroscientists

Zero to Three/National Center for Clinical Infant Programs: Represents 7,500 programs for high risk children and families, as well as individuals

Endnotes

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2. *Just the Facts: A Summary of Recent Information on America's Children and Their Families*. Washington, DC: National Commission on Children, 1993: p.59.

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4. *The State of America's Children, Yearbook 1994*. Washington, D.C.: Children's Defense Fund: pp.xiii, 19, 53.

5. Kaplan, George R. *Images of Education: The Mass Media's Version of America's Schools*. Washington, DC: Institute for Educational Leadership/National School Public Relations Association, 1992: p.3.

6. *The Facts: School-Based and School-Linked Health Centers*. Washington, D.C.: Advocates for Youth, February 1994.

7. The fact that children's health and educational status are linked and interdependent is increasingly a common understanding among all child and youth serving professionals. For more detailed and comprehensive discussions of the link between health and education (and vice versa) please read some of NHEC's earlier publications, which are listed in the appendices of this report.

8. *The Answer Is At School: Bringing Health Care To Our Students*. Washington, D.C.: The School-Based Adolescent Health Care Program, 1993: p.8.

9. Definitions are taken from a June, 1994 working meeting convened by Advocates for Youth in Washington, DC and reflect work conducted by Joy Dryfoos and the Advocates for Youth Staff as well as comments from meeting participants.

10. Guthrie, Grace Pung and Larry F. Guthrie, "Streamlining Interagency Collaboration for Youth at Risk." *Educational Leadership*, September 1991: p.17.

11. *National Survey Results on Drug Use from the Monitoring The Future Study, 1975-1992, Vol I*. Rockville, MD: U.S. Department of Health and Human Services: p.133.

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13. *Community Childhood Hunger Identification Project — A Survey of Childhood Hunger in the United States*. Washington, D.C.: Food Research and Action Center, March 1991: p.11.

14. *School-Based and School-Linked Health Centers, Update 1993*. Washington, D.C.: The Center for Population Options, 1994: p.31.

15. Ibid., p.29.

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17. Lear, Julia; Hope Cleicher, et al. "Reorganizing Health Care for Adolescents: The Experience of the School-Based Adolescent Health Care Program." *Journal of Adolescent Health*, Volume 12 (No. 6), 1991: p.452.

18. Frieden, Joyce. "School-Based Clinics: More Than Aspirin and Icepacks." *Pediatric News*, November, 1994: p.33.

19. Ravenet, S. DuBose. "Opposing Opinions: Are School-based health clinics a good idea — No." *Pediatric News*, November, 1994: p.33.

20. Much of this section is taken from "History of School-Based Services and School-Based Clinics" in *School-Based Health Clinics: A Guide To Implementing Programs*. Washington, DC: Advocates for Youth, 1986: pp.8-9.

21. McKinney, Debra Hauser and Geri Lynn Peak. *School-Based and School-Linked Health Centers*. Washington, DC: Advocates for Youth, 1994: p.1.

22. Dryfoos, Joy. G. *Full-Service Schools — A Revolution in Health and Social Services for Children Youth and Families*. San Francisco, CA: Jossey-Bass, Inc., 1994: p.192.

23. Three reports comprise the Office of Technology Assessment's adolescent health series: *Adolescent Health Volume One: Summary and Policy Options* (052-003-01234-1), *Adolescent Health Volume Two: Background and Efficiency of Select Preventive Services* (052-003-01235-9), and *Adolescent Health Volume 3: Cross-Cutting Issues in the Delivery of Health and Related Services* (052-003-01236-7). They are no longer available from OTA itself, but may still be obtainable by calling the Government Printing Office at (202) 512-1800 or by calling National Technical Information Services at (703) 487-4650 — NTIS ordering numbers for the reports are as follows: Volume One: PB91-197921, Volume Two: PB92-157577, Volume Three: PB91-212183.

24. The Steelman Commission report, a multi-volume set with a summary report, is no longer available from the Advisory Council on Social Security itself, but may be available from the Government Printing Office at (202) 512-1800.

25. *School-Based Health Centers and Managed Care* (OEI-03-92-00680) and *School-Based Health Centers and Managed Care: Examples of Coordination* (OEI-03-92-00681) are companion reports available from the DHHS Office of the Inspector General by calling the staff at (202) 619-1142 and requesting the OEI numbers listed in parentheses above. The office has a voice mail system for orders when a staffer is not available to answer the phone.

26. General Accounting Office (GAO) reports are available by calling their publications department at (202) 512-6000.

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McKinney, Debra and Peak, Geri. *School-Based and School-Linked Health Centers: Update 1993*. Washington, DC: Advocates for Youth, 1994.

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The Facts: School-Based and School-Linked Clinics. Washington, DC: Advocates for Youth (Center for Population Options), 1991.

The Future of Children: School-Linked Services. Los Altos, CA: Center for the Future of Children, The David and Lucille Packard Foundation, Spring 1992.

The State of America's Children. Washington, DC: Children's Defense Fund, 1992.

Together We Can: A Guide for Crafting a Profamily System of Education and Human Services. Washington, DC: U.S. Department of Education; U.S. Department of Health and Human Services, April 1993.

National Health & Education Consortium • Publication List and Order Form

Please indicate the number of publications requested in the spaces provided.

___ ***Starting Young: School-Based Health Centers at the Elementary Level*** (Special Report) — provides historical and current info. on school-based health care with additional info. on staffing patterns, funding, and the value of preventive health care to elementary age children; produced in collaboration with the National Association of Elementary School Principals. (1993, $10)

___ ***Putting Children First: State-Level Collaboration Between Education and Health*** (Special Report) — describes interventions used in four pilot states (Florida, Maryland, New Mexico and Texas) to promote collaboration between the health and education sectors; provides suggestions to state leaders working to foster similar collaborative relationships. (1993, $10)

___ ***Fetal Alcohol Syndrome: The Impact on Children's Ability to Learn*** (Occasional Paper #10) — examines the root causes and consequences of Fetal Alcohol Syndrome and its impact on a child's ability to learn; describes some innovative programs and suggests recommendations for action; produced in collaboration with the Children of Alcoholics Foundation. (1991, $5)

___ ***Texas' Youth, Texas' Future*** (Special Report) —produced for NHEC by IEL's Center for Demographic Policy, identifies the demographic trends of Texas' children at health and educational risk and provides data to facilitate collaborative planning strategies for the education and health systems. (1993, $12)

___ ***Florida's Youth, Florida's Future*** (Special Report) — produced for NHEC by IEL's Center for Demographic Policy, identifies the demographic trends of Florida's children at health and educational risk and provides data to facilitate collaborative planning strategies for the education and health systems. (1993, $12)

___ ***School Nursing: Trends for the Future*** (Occasional Paper #6) — Carole Passarelli of the Yale School of Nursing highlights the increased need for school health nurses — providing recommendations for the best use of these essential professionals; illustrating various settings in which school nurses play an integral role; and describing current progressive school nurse programs. (1993, $5)

___ ***Eat to Learn, Learn to Eat: The Link Between Nutrition and Learning in Children*** (Special Report/Occasional Paper #7) — provides an overview of the link between nutrition and learning in children; describes the successes and limitations of public and private child nutrition programs; suggests action steps improve children's nutritional status; produced in collaboration with the American School Food Service Association. (1993, $10)

___ ***Children's Mental Health and Their Ability to Learn*** (Occasional Paper #8) — written by the National Mental Health Association, examines the current status of children's mental health and its impact on children's ability to learn; includes info. on services available to address needs and suggests policy and action steps to improve the provision, availability and accessibility of these services. (1993, $5)

___ ***The Poisoning of America's Children: Lead Exposure, Children's Brains and the Ability to Learn*** (Occasional Paper #6) — Dr. Herbert Needleman of the University of Pittsburgh provides a comprehensive overview of lead poisoning, presenting research that demonstrates the long and short-term effects of low level lead exposure on children's intellectual ability and social adjustment. (1992, $5)

___ ***Health/Education Collaboration: Insights Into Six Field Activities*** (Occasional Paper #5) — describes five NHEC-sponsored community initiatives and analyzes implications for future activities. (1992, $5)

___ ***Bridging the Gap: An Education Primer for Health Professionals/A Health Care Primer for Education Professionals*** (Special Report) — this two-part primer describes the health and education systems and how professionals from both fields can work collaboratively. (1992, $12)

___ ***At Risk Does Not Mean Doomed*** (Occasional Paper #4) — Craig T. Ramey and Sharon L. Ramey, Co-Directors of the Civitan International Research Center of the University of Alabama at Birmingham, analyze the results of their research in early intervention programs for children. The research not only shows that these programs can significantly improve school readiness, but moreover demonstrates that certain types of children are in greater need of early intervention. (1992, $5)

___ ***Creating Sound Minds and Bodies: Health and Education Working Together*** (Special Report) — examines health education policy environments and suggests collaboration at the federal, state and local levels; catalogues ongoing activities and provides an annotated bibliography of resources. (1992, $10)

___ ***Cocaine-Exposed Children: A Growing Health/Education Issue*** (Occasional Paper #3) —provides an overview of how cocaine and general drug use during pregnancy affect the health and ultimate learning potential of infants; offers action steps to help prevent the problems associated with drug exposure during pregnancy. (1992, $5)

___ ***"Help Me Learn, Help Me Grow"/"Ayudame A Aprender, Ayudame A Crecer"*** (Project Materials) —a bilingual, multimedia, parent awareness project. Materials are designed to be administered by professionals to help educate parents on the link between their child's health and education. (Starter Set — 1 video (Spanish, English), 40 posters, posters (Spanish, English, or mixed), 20 magnet notepad sets, 1 community action guide — $28 — *indicate desired language of materials*) **Items are also sold individually.**

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